CENTERS FOI	R MEDICARE & MEDI	CAID SERVICES				O	MB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE (CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	01	COMP	PLETED
		155694	B. WIN			09/14/	2011
			B. WIIV		T ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			BETZ RD		
BETZ NU	JRSING HOME			1	JRN, IN46706		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	N.	(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE .	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	NAIL	DATE
K0000							
	A Life Safety C	Code Recertification	K	0000	The creation and submiss		
	and State Licensure Survey was				this Plan of Correction doe		
		the Indiana State			constitute an admission by		
	Department o				provider of any conclusior forth in the statement of	Set	
	· ·				deficiencies, or of any viol	ation of	
	accordance w	ith 42 CFR 483.70(a).			regulation.This provider		
	Survey Date:	09/14/11			respectfully requests that 2567 Plan of Correction b considered the Letter of C	е	
	Facility Numb	er: 000306			Allegation and requests a	Post	
	Provider Num				Survey review on or after	October	
					14, 2011.		
	AIM Number:	100273860					
	Surveyor: Am	y Kelley, Life Safety					
	Code Specialis	st					
	At this Life Sa	fety Code survey,					
	Betz Nursing I	Home was found not					
	_	with Requirements					
	for Participation	·					
	•						
	Medicare/Med	•					
	•	70(a), Life Safety					
	from Fire and	the 2000 edition of					
	the National F	ire Protection					
	Association (N	NFPA) 101, Life Safety					
		hapter 19, Existing					
		· ·					
		ccupancies and 410					
	IAC 16.2.						
	This one story	facility was					
	determined to	be of Type V (000)					
	construction a	• •					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4IPJ21

Facility ID: 000306

PRINTED: 10/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155694		(X2) MULT A. BUILDI B. WING		ot	(X3) DATE S COMPL 09/14/20	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN46706				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0014 SS=E	alarm system we detection in the areas open to the facility has a called had a census of this survey. Quality Review by Force Specialist-Medical Code Code Specialist-Medical Code Specialist-Medical Code Code Specialist-Medical Code Code Specialist-Medical Code Code Code Code Code Code Code Code	he corridors and he corridors. The pacity of 115 and f 93 at the time of Robert Booher, Life Safety dical Surveyor on 09/20/11. If found not in he the diregulatory is evidenced by the sevidenced by the sevidenced by the ass A or Class B. Vation and acility failed to entation for the ating of interior installed within 6 of 7 corridors in its deficient practice occupants except	K00	14	K014It is the practice of this provider to provide flame spr rating of interior finish materials. What corrective Ac will be accomplished for thos residents found to have been affected by the deficient practice? The maintenance supervisor/designee has obtathe data sheets indicating the classification of flooring. He keep the information in a bind or file folder. This will be	tion e n ained e fire will	10/14/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4IPJ21

Facility ID: 000306

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155694	A. BUI	LDING	01	09/14/2	
		133094	B. WIN			09/14/2	011
NAME OF P	ROVIDER OR SUPPLIEF	1		116 BE	ADDRESS, CITY, STATE, ZIP CODE		
BETZ NU	IRSING HOME			1	RN, IN46706		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	accessible to any person who		DATE
	a. Based on observations with the Maintenance Supervisor on 09/14/11 during the tour from 12:40 p.m. to 2:08 p.m., carpet was installed on the nurses' desk at the west and central nurses' station. Also, carpet was installed on the wall below the reception window in the center hall.				information in order to ensure safety of those in the building. How will you indentification other residents having the potential to be affected by the same deficient practice and corrective action will be taked residents have the potential affected by the alleged deficipractice. The maintenance supervisor/designee has this information in his file drawers	fy e what n?All to be ent	
		oservations with the			will be sure that the manager		
	Maintenance Si				team is aware of it's whereat		
		1 2:47 p.m. to 2:49			and make it easily	وط النب	
		flooring material			accessible.What measures v put into place or what systen		
	was installed o				changes will you make to ins	ure	
		corridor wall on			that the deficient practice do		
	400, 500, 600				not recur?All new materials was be logged and the flame spread		
		terview with the			rating sheets filed in the		
	Maintenance Si	upervisor at the			maintenance director's binde		
		ations, this was			folder.How will the corrective action be monitored to ensur		
	done recently a				deficient practice will not rec		
	renovation pro				i.e., what quality assurance program will be put into place	₋₂ Δ	
		terview with the			Life Safety Review CQI tool		
		upervisor at the			be utilized. The Executive		
	time of observa				Director is responsible to ens	sure	
		was available to			compliance. This will be submitted for review at the		
		ne carpet and the			monthly safety meeting if		
	laminate floori	-			threshold not achieved.		
	_ -	ne spread rating of					
	Class A or Class B.						
	3.1-19(b)						

PRINTED: 10/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155694		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN46706				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
K0017 SS=E	walls constructed resistance rating. partitions are only passage of smoke buildings, walls proceiling. (Corridor underside of ceilin permitted by Code stations, waiting a activity spaces may under certain condiff shops may be by non-fire rated with sprinklered.) 19 Based on observinterview, the fensure 1 of 1 lewas separated by a partition of the passage of Exception. LSC Exception # 6, patient sleeping rooms, and has be open to the unlimited in are space and corrispace opens or	acility failed to counges on 700 hall from the corridors apable of resisting smoke, or met an 19-3.6.1, Spaces other than g rooms, treatment cardous areas may corridor and ea provided: (a) The dors which the ato in the same tment are protected ly supervised	K0017	It is the practice of this providensure that each space is protected by an electrically supervised automatic smoke detection system. What correaction will be accomplished fithose residents found to have been affected by the deficien practice? The maintenance director worked with the contruction manager to get the smoke detector installed by SafeCare on 9/20. How will you indentify other residents have the potential to be affected by same deficient practice and corrective action will be taken? Four (4) residents were potentially affected. The maintenance director will condaily inspections during the remaining construction period	ctive for e int ne ou ing y the what		

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Event ID: 4IPJ21

Facility ID:

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155694	B. WIN	IG		09/14/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
				116 BE		
BEIZNU	JRSING HOME			AUBUR	RN, IN46706	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	,	DATE
	system, and (b)				insure that any potential area smoke passage is electronic	
	protected by ar				monitored by the automatic	uny
	sprinklers, and	(c) The space is			smoke detection system.Wha	at
	arranged not to	o obstruct access to			measures will be put into pla	
	required exits.	This deficient			what systemic changes will y make to ensure that the defice	
	practice could a	affect four residents			practice does not	JOH L
	on the 700 hall				recur?Maintenance director v	will
					make a written report to	
	Findings includ	e:			Executive Director and	1.2
	_				Construction Manager of his findings of any areas that ne	
	Based on an ob	servation with the			be electronically monitored b	l l
	Maintenance Su				automatic smoke detection	,
		07 p.m., the newly			system.How will the corrective	II
		00 hall lounge was			action be monitored to ensur	
		the corridor by a			deficient practice will not reci i.e., what quality assurance	ur,
	•	all. Furthermore,			program will be put into	
					place?The written report will	be
	="	requirement (a) of			discussed in morning meetin	~ I
		19-3.6.1 was not			and in monthly safety commi for the duration of the	ttee
		e 700 hall lounge			construction project.	
	was not protect	=			, , , , , , , , , , , , , , , , , , ,	
		ervised automatic				
		n system. This was				
	_	by the Maintenance				
	Supervisor at th	ne time of				
	observation.					
	3.1-19(b)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155694	B. WING			09/14/2	011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN46706				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0018 SS=E	Doors protecting of than required enclexits, or hazardous doors, such as the solid-bonded core resisting fire for at sprinklered buildin resist the passage impediment to the are provided with a keeping the door of meeting 19.3.6.3.6. Roller latches are regulations in all hall. Based on obtainterview, the frensure 1 of 8 recorridor doors and latched into This deficient pany of the 13 rehall. Findings include Based on obsert Maintenance Supplies and the sure 1 of 8 recorridor doors and latched into This deficient pany of the 13 rehall. Findings include Based on obsert Maintenance Supplies and the sure 1 of 8 recorridor door to 207 failed to late frame. This was the Maintenance time of observations of the sure of	corridor openings in other osures of vertical openings, is areas are substantial ose constructed of 1¾ inch wood, or capable of least 20 minutes. Doors in ings are only required to e of smoke. There is no closing of the doors. Doors a means suitable for closed. Dutch doors are permitted. 19.3.6.3 prohibited by CMS ealth care facilities. Oservation and facility failed to esident room on 200 hall closed of the door frame. Oractice could affect esidents on the 200 de: Total or with the approximation of the door in th	K0	018	It is the practice of this provice ensure there is no impediment the closing of doors that resist passage of smoke. What corrective action(s) will be accomplished for those reside found to have been affected the deficient practice? The doon room 207 was repaired by maintenance on the day of survey. The knob was adjust and the door now latches into frame. The glove box holding open the door of the central supply room was removed or of survey and will no longer by propped open. How will you identify other residents havin potential to be affected by the same deficient practice and corrective action will be taker residents have the potential taffected by the alleged deficipractice. Repair service was performed/completed by maintenance staff immediate	ents by or / ted or the ents o	09/14/2011
	3.1-19(b)				upon finding it was needed.V	/hat	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694		(X2) MUL A. BUILD B. WING	DING	01	(X3) DATE S COMPL 09/14/2	ETED	
	PROVIDER OR SUPPLIEF			116 BET	DDRESS, CITY, STATE, ZIP CODE Z RD N, IN46706		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	to the closing of doors protection openings. This was not in a recould affect and Findings include Based on observation, he be propped op	Facility failed to ere no impediments of 1 of 3 service hall ing corridor is deficient practice sident care area but y number of staff. The: Tryation with the supervisor on the central supply open with a lased on an the Maintenance			measures will be put into plat what systemic changes will make to ensure that the deficient practice does not recur? Mon CQI tool will be implemented times 3 months and then quarterly thereafter to check resident room doors latch interame and that no doors have anything impeding their closs the event of smoke. How ill the corrective action be monitored ensure the deficient practice not recur, i.e., what quality assurance program will be point place? Maintenance director/designee will review environmental safety-resider area CQI tool at the monthly safety committee meeting. The Executive Director is responsite to ensure compliance.	you cient thly that o e ure in ne ed to will ut	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING			ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN46706				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
K0025 SS=E	least a one half he accordance with 8 terminate at an atriprotected by fire-raglass panels and stwo separate compeach floor. Dampe penetrations of smheating, ventilating systems. 19.3.7 19.1.6.4 Based on observing the passage of conduit throug barrier walls we maintain the smeach smoke ba 19.3.7.3 require to be construct with LSC Section 8.3.6.1 require building service pipe, cable or was the space be penetrating items according to be constructed by the space be penetrating items according to the space because the space according to the space because the space beca	acility failed to etrations caused by wire and/or h 3 of 7 smoke ere protected to moke resistance of rrier. LSC Section es smoke barriers ed in accordance n 8-3. LSC Section s the passage of e materials such as wire to be protected etween the m and the smoke	K00	25	It is the practice of this provice ensure that penetrations of the smoke barriers are filled with material capable of maintaini the smoke resistance of the smoke barrier. What corrective action will be accomplished for those residents found to be affected by the deficient practice? The drywall in the around of the 700 smoke barrier was replaced/repaired by maintenance on 9-20-11. Expandable foam was removed in the smoke barrier between central and east hal was resealed with fire retardace caulk on 9-22-11. He smoke barrier by the activity office he had the 3 areas sealed with fretardant caulk on 9-22-11. He will you identify other residen having the potential to be affected.	ne ng e or tttic as r I. It ant as ire ow tts	09/22/2011

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Event ID: 4IPJ21

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	LDING	01	COMPL	LETED
		155694	B. WIN			09/14/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		116 BE			
BET7 NI	JRSING HOME			1	RN, IN46706		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)	+	TAG	,		DATE
	the smoke res	istance of the smoke			by the same deficient praction was and what corrective action w		
	barrier or be p	rotected by an			taken?All residents have the		
	approved devi	ce designed for the			potential to be affected by the		
	specific purpo	se. This deficient			alleged deficient practice.Re		
	1	affect six of eight			were performed/completed I	-	
	smoke compai				maintenance upon finding.A		
	silioke collipai	unents.			compartments were inspect		
	l	_			upon this survey and no oth		
	Findings inclu	de:			alleged deficient practice for needing action.What measu		
					will be put into place or what		
	Based on obse	rvations with			systemic changes will you m		
	Maintenance S	upervisor on			to ensure that the deficient		
	09/14/11 fror	n 3:20 p.m. to 3:35			practice will not recur?Durin	g the	
		wing smoke barrier			remainder of construction ar	nd as	
	I *	-			appropriate thereafter,		
		ealed penetrations or			Maintenance		
	penetrations s				Supervisor/designee will foll behind any work on or near	ow	
	unrated mater				smoke barriers to assure the	ere is	
	a) in the attic (of the 700 smoke			no penetration that will provi		
	barrier wall the	ere was a section of			way for smoke to travel thru		
	drywall remove	ed measuring three			written report will be provide		
	feet tall by one				the Executive Director of an		
	1	foam which was not			findings.How will the correct		
	· ·	used to seal at least			action be monitored to ensu		
					deficient practice will not rec i.e., what quality assurance	ui,	
		ions in the smoke			program will be put into		
		tween the central			place?Maintenance		
	and east hall				director/designee will review		
	c) in the attic (of the smoke barrier			findings and corrective actio	ns at	
	wall by the Act	tivities office a three			monthly Safety Committee		
	inch sleeve, a	two inch sleeve and			meeting.		
	•	penetration had					
	not been seale	•					
		owledged by the					
		- ·					
		upervisor at the					
	time of observ	ations.					l

PRINTED: 10/14/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 01 COMPLETED					
		155694	A. BUILD B. WING			09/14/2	011
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN46706				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	P	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0029 SS=E	One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro When the approve extinguishing syste are separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1 1. Based on obtinterview, the facensure the corresponding to the correspon	d construction (with ¾ hour ran approved automatic fire em in accordance with 8.4.1 of beets hazardous areas. It dautomatic fire em option is used, the areas in other spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 inches is the door are permitted. It is exervation and acility failed to idor door to 1 of 1 oms, a hazardous all was provided ing device. This is ce could affect any the 200 hall water	K00		It is the practice of this provion have self closing doors and/ordoors that latch into the door frame on corridor doors of hazardouse areas(water hear rooms and soiled utility rooms). What corrective action be accomplished for those residents found to have been affected by the deficient practice? Maintenance supervisor/designee replaced self closing device on the 200 water heater room. Additional latching door handles were installed on the soiled utility rodoors in the 400, 600, and 700.	ter n will the hall ally, oom	09/23/2011
		•			hallways.How will you identify	y	
	09/14/11 at 1:	•			other residents having the potential to be effected by the	<u>.</u>	
		the 200 hall water			same deficient practice and v		
	neater room wa	as equipped with a			corrective action will be taker		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DING	01	COMPLETED
		155694	A. BUII B. WIN			09/14/2011
		<u> </u>	B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIEF	₹		116 BE		
BET7 NI	JRSING HOME				RN, IN46706	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
1710			+	1110	residents had the potential to	
	self closing dev				effected by the alleged defici	
	l -	vice had a feature			practice. Maintenace	
		d the door open.			supervisor/designee has	
		owledged by the			completed the change of the	
	Maintenance Si	upervisor at the			defective hardware.What measures will be put into pla	ce or
	time of observa	ations.			what systemic changes will y	• • • • • • • • • • • • • • • • • • •
					make to insure that the defic	
	3.1-19(b)				practice does not recur?CQI	
					for environmental safety will	
	2. Based on ol	oservation and			implemented. Results will be monitored by environmental	;
	interview, the f	facility failed to			services.How will the correct	ive
	ensure the cor	ridor door to 3 of 6			action be monitored to insure	
	shower rooms	used for storage of			deficient practice will not rec	ur,
	soiled linen, th	erefore creating a			i.e., what quality assurance	
		a, were provided			program will be put into	
		t would self close			place?Maintenance supervisor/designee will repa	air
		the frame. This			any negative results found of	• • • • • • • • • • • • • • • • • • •
		ice could affect any			CQI tool and review the resu	
	· ·	ents on the 400,			the monthly Safety committe	e
	600 and 700 h				meeting.	
	600 and 700 n	alls.				
	Findings includ	le:				
		rvation with the				
	Maintenance Si					
	09/14/11 from	n 2:31 p.m. to 3:05				
	p.m., soiled lin	en barrels were				
	stored in the 4	00, 600 and 700				
	shower rooms.	These shower				
	rooms lacked I	atching hardware				
		ch into the door				
		on an interview with				
		ce Supervisor at the				
	i the Mannenand	Le supervisor at the				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155694	B. WING			09/14/2	011
NAME OF P	PROVIDER OR SUPPLIER	<u> </u> 	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		•		116 BE			
BETZ NU	JRSING HOME			AUBUR	RN, IN46706		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	` ·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
IAG			-	IAG	DEFICIENCE TY		DATE
		ations, soiled linen					
	is stored in these barrels until they are taken by the laundry staff to						
		·					
	the laundry roo	om.					
	3.1-19(b)						
	3.1-19(b)						
K0038		anged so that exits are					
SS=E	readily accessible with section 7.1.	at all times in accordance					
	1. Based on ol		KO	038	It is the practice of this provide	der to	10/14/2011
	interview, the f			050	insure that all exits are readi		10/11/2011
		exit discharge paths			available at all times.What		
		essible at all times.			corrective action will be accomplished for those residents		
		oractice could affect			found to have been effected		
	-	evacuated through			the deficient	•	
	-	kit in the event of an			practice?Maintenance		
		art in the event of an			supervisor/designee will repl the door handle on the exter		
	emergency.				door thus allowing the interior		
	Findings includ	lo:			door to open completely for		
	i manigs meiae	ic.			evacuation purposes. Temp ramps will be put into place a		
	Rased on obse	rvation with the			300, 500, and 700, hall exits		
	Maintenance Si				the black top is installed. Sig	ns	
		:10 p.m., the 200			were ordered 9-30-11, to not	ify all	
		oors less than foot			that the magnetic lock would release when the cras	h har	
		e exit path. When			was pressed for 15 seconds		
	=	vas opened into a			will you identify other resider	nts	
		it hit the second			having the potential to be eff		
					by the same deficient practice and what corrective action w		
	door and could not be opened completely. The second door had to be opened in order to open the			taken?There were 73 reside			
					potentially effected by this al		
				deficient practice. By 10-14-			
	first door completely. This was				Maintenance supervisor/designee will replace the door handle on		
	acknowledged	by the Maintenance			will replace the door handle	J11	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DING	01	COMPL	ETED
		155694	A. BUII B. WIN			09/14/2	011
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		116 BET			
DET7 NI	JRSING HOME				N, IN46706		
DETZING	TROING HOME		_	AUBUR	N, 11140700		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Supervisor at t	he time of			the exterior door thus allowing		
	observation.				interior door to open comple	-	
					for evacuation purposes. He place temporary ramps wide		
	3.1-19(b)				enough to roll a bed over,		
	3.1-19(b)				providing egress from the bu	ildina	
		_			for the four inch drop created		
	2. Based on o	bservation and			preparing for the new blackto	-	
	interview, the	facility failed to			the drives. He will install the		
	ensure 3 of 9 e	exit discharge paths			notifying how to operate the	door	
	were readily ac	cessible at all			in case of emergency		
	I -	ction 4.6.10.1 says			evacuationWhat measures v		
		•			put into place or what system		
	l ⁻	ildings shall be			changes will you make to ins that the deficient practice do		
	l -	e occupied during			not recur?Exits will be check		
	construction a	nd repairs only			maintenance supervisor/des	•	
	where required	d means of egress			every 6 months to insure that	-	
	and required f	ire protection			exit doors can be opened to		
	features are in	place and			maximum potential and that		
		naintained for the			is less than a four inch drop		
	1				concrete to blacktop drive. It		
	portion occupi				be verified that there is nothing	•	
		safety measures			impeding the full operation of exits for evacuation purpose		
	acceptable to t	the authority having			that time, it will also be verifi		
	jurisdiction are	e in place. This			that the sign with operation	ou	
	deficient pract	ice affects any of			directions for the 600 hall do	or is	
	· ·	ts on the 300, 500			still in place and legible.How	will	
	1	in the event of an			the corrective action be mon	itored	
	l	in the event of an			to insure the deficient practic	ce will	
	evacuation.				not recur, i.e., what quality		
					assurance program will be p into place?Maintenace	ut	
	Findings includ	de:			supervisor/designee will con	nolete	
					a Life Safety CQI tool bi-ann		
	Based on obse	rvations with the			in October and April. This w		
	Maintenance S	upervisor on			reported in the monthly CQI		
	1	n 12:48 p.m. to 3:12			meeting of those months. T	he	
	1				Executive Director will be		
	I -	ktop road has been			responsible for to insure		
	removed from	the 300, 500 and			compliance.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694			LDING	ONSTRUCTION 01	(X3) DATE SU COMPLE 09/14/20	TED	
	PROVIDER OR SUPPLIEI	<u> </u>	B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE TZ RD RN, IN46706	l	
(X4) ID PREFIX	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	700 hall exit e	gress path in r a new blacktop					
	road. The rem	oval of the blacktop					
	created a four each of these o	inch drop off at					
		were provided by					
		ce Supervisor at the					
	time of observ	ations.					
	3.1-19(b) 3. Based on observation and						
		facility failed to					
	ensure the me						
	_	delayed-egress					
		ily accessible for all					
	1	f and visitors. LSC					
		yed Egress Locks					
	requires all ap						
	delayed egress						
	l '	e installed on doors					
	_	d ordinary hazard					
	throughout by	ildings protected					
	supervised aut						
	detection syste						
	I	th Section 9.6, or an					
		ervised automatic					
	sprinkler syste						
	l ·	th Section 9.7, and					
		ed in Chapters 12					
	· ·	ovided: On the door					
		e release device,					

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155694		(X2) MULTIPLE CO A. BUILDING B. WING	01	COMP: - 09/14/2	LETED	
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP COI TZ RD RN, IN46706	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	durable sign in than 1 inch hig inch in stroke was contrasting base reads: "PUSH USOUNDS. DOO IN 15 SECONDS practice could residents on the evaluated through exit in the every findings included the exit in the every findings included the exit in the every findings included the exit door of provided with a magnetic lock when the crash for fifteen second provided was ign. This was	ckground that UNTIL ALARM R CAN BE OPENED S". This deficient affect any of the ten e 600 hall ugh the 600 hall at of an emergency. de: Evation with the upervisor on 55 p.m., the 600 rom the facility was a delayed egress that would open bar was pressed ands. The door was ith the required acknowledged by the Supervisor at the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		ONSTRUCTION 01	(X3) DATE : COMPL		
		155694	B. WIN			09/14/2	011
		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		116 BE AUBUR	ADDRESS, CITY, STATE, ZIP CODE TZ RD RN, IN46706 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
K0048 SS=F	There is a written patients and for the of an emergency. Based on record interview, the faprovide a compplan that include kitchen fire ext protection of 92 the event of an 19.7.2.2 requir care occupancy that shall provide following: (1) Use of alarm (2) Transmission fire department (3) Response to (4) Isolation of (5) Evacuation of (6) Evacuation of (6) Evacuation of (7) Preparation building for evaluation of (8) Extinguishm This deficient pall occupants in	plan for the protection of all eir evacuation in the event 19.7.1.1 dreview and acility failed to plete written fire led the use of inguishers for the 3 of 93 residents in emergency. LSC es a written health fire safety plan de for the 1 of alarm to the 1 of immediate area of smoke 1 of floors and acuation ment of fire practice could affect in the event of an en the written fire immediately	K	0048	It is the practice of this provice provide a complete written fir plan to be immediately availating the event of an emergency. What corrective action will be accomplished if those residents found to have been effected by the deficient practice? A complete, facility specific fire safety plan, inclusting the use of kitchen fire extinguishers, is now written immediately available. How we you identify other residents having potential to be effected the same deficient practice at what corrective action will be taken? All residents have the potential to be effected by the alleged deficient practice. The entire disaster action plan was revised and has all current information including the use the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen hood extinguishing system. What measures will be put into place or what system changes will you make to insthat the deficient practice does not recur? Inservices will be conducted in October and November regarding the new disaster policy and the location of those manuals in the build Additionally, the new policy we reviewed at the monthly CQI	re able for e t ding and rill ed by and e e e as e of e e oe oes e ing. vill be	10/14/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155694	A. BUI	LDING	01	COMPL 09/14/2	
		100094	B. WIN			09/14/2	011
NAME OF F	PROVIDER OR SUPPLIER			116 BE	ADDRESS, CITY, STATE, ZIP CODE		
BETZ NU	JRSING HOME			1	RN, IN46706		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\neg	ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Based on a reco	ord review with the			meeting as well as the montl safety meeting.How will the	hly	
	Maintenance Su	ipervisor on			corrective action be monitored to insure the deficient practice will	ed to	
	09/14/11 from						
	12:10 p.m., the			not recur, i.e., what quality			
	⁻	he written fire plan			assurance program will be p into place?The Executive Di		
		in three separate			will be responsible to monito		
		s. The Maintenance			plan monthly and make char	nges	
	l '	le numerous trips			as appropriate.		
	to the administ						
	searching for the required information. Portions of the						
	· -	n were found in the					
	following docu						
	· '	aster Plan Policy &					
		ual Revised 03/09					
	b) the ASC (Am						
	Communities) S	· · · · · · · · · · · · · · · · · · ·					
		01/01/04. Revision					
	date 01/01/08						
	c) the Disaster						
		ASC two weeks ago.					
		he corporate policy					
	<u> </u>	nformation specific That information					
	was not include						
	Additionally, no						
	I	ssed the use of the					
		nguisher located in					
		elationship with the					
	use of the kitch	=					
	extinguishing s						
	Based on an int	•					
	Maintenance Su						
	mannenance 30	1pc(1)30(, A3C					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DITII	DING	01	COMPL	ETED	
		155694	B. WING 09/14/2		011		
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	L		116 BE			
	RSING HOME			AUBUR	N, IN46706		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PREFEX (EACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re l	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCE		DATE
	purchased the	facility one year					
	ago.						
	3.1-19(b)						
			1				
K0052		n required for life safety is					
SS=E	installed, tested, a						
		IFPA 70 National Electrical					
		2. The system has an ance and testing program					
	• •	plicable requirements of					
	NFPA 70 and 72.						
	Based on obser		$ _{K0}$	052	It is the practice of this provide	der to	09/14/2011
	interview, the f				ensure a fire alarm system		03,70 1,7000
		nanual pull stations			required for life safety is insta		
		•			tested, and maintained. The		
		were maintained			system has an approved maintenance and testing pro	oram	
		oility. NFPA 72,			complying with the applicable	-	
	•	fire alarm system			requirements.What corrective		
	equipment be p	periodically			action will be accomplished f		
	maintained in a	accordance with			those residents found to have	-	
	manufacturer's	instructions. This			been affected by the deficien practice?Repair service was		
	deficient practi	ce could affect any			performed/completed by		
		ents on the 500			SafeCare and determined ca	use	
	hall.				of trouble was that the manu		
					pull stations had not been wi		
	Findings includ	lo:			when the panel was moved f	or	
	i illulligs illeluu	ic.			renovation. Fire watch was		
		· ·			ensured proper functioning.		
	alarm system to	esting on 09/14/11			will you identify other resider		
		upervisor during fire				nd łow	

OF CORRECTION	IDENTIFICATION NUMBER: 155694	A. BUII	LDING	01	COMPI 09/14/2	LETED
at 3:50 p.m., r manual pull states the 500 hall act alarm system of test. Based on the Maintenand time of observ aware of this p	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) Tone of the three ations located on tuated the fire during the fire alarm an interview with ce Supervisor at the ation, he was not problem and stated larm panel was	B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE TZ RD N, IN46706 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) having the potential to be aff by the same deficient practic and what corrective action we taken? Fourteen (14) residen had the potential to be affect the alleged deficient practice. Repair service was performed/completed by SafeCare and determined or of trouble was that the manupull stations had not been we when the panel was moved renovation. Fire watch was implemented until Safecare completed repair, completed testing on the pull stations, a ensured proper functioning. I measures will be put into play what systemic changes will make to ensure that the definity practice does not recur? Fire will be conducted, by the Maintenance Supervisor designee, monthly using the effected pull stations to insure they are working properly. A mal-function will be reported executive Director and Safe immediately How will the corrective action be monitor ensure the deficient practice not recur, i.e., what quality assurance program will be printo place? Maintenance Supervisor/designee will reverse drill reports and Life Sac CQI tool at the monthly safe committee meeting. The Executive Director is response to ensure compliance.	fected ce vill be ts ted by e. ause ual irred in for d and What ace or you cient e drills for e can be will but riew fety ty	(X5) COMPLETION DATE

PRINTED: 10/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		1			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155694	B. WIN			09/14/2	011
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	ROVIDER OR SOLI EIER			116 BE			
BETZ NU	JRSING HOME			AUBUR	N, IN46706		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENC1)		DATE
K0056 SS=E	installed in accord Standard for the Ir Systems, to provice portions of the built properly maintaine 25, Standard for th Maintenance of W Systems. It is fully reliable, adequate system. Required equipped with wat switches, which ar the building fire ala 1. Based on ob- interview, the fi- ensure a compl sprinkler system 1 of 4 building accordance wit Standard for In Sprinkler System complete cover of the building. Edition, Section sprinklers shall exterior roofs of exceeding 4 feed deficient practi resident evacua 300 hall in the emergency.	pservation and facility failed to lete automatic m was provided for overhangs in h NFPA 13, stallation of ms, to provide rage for all portions. NFPA 13-1999 in 5-13.8.1 requires be installed under or canopies et in width. This ce could affect any ated through the event of an let.	K	0056	It is the practice of this provide insure that there is an autom sprinkler system that provide complete coverage for all po of the building. What correctivaction will be accomplished those residents found to have been effected by the deficier practice? PIPE, Inc has instate sprinkler head under the overhang on the 300 hall exite in the front office area. How we you identify other residents having potential to be effected the same deficient practice awhat corrective action will be taken? 10 residents had the potential to be effected by the alleged deficient practice. PI Inc has installed a sprinkler hunder the overhang on the 3 hall exit and in the front office area. What measures will be into place or what systemic changes will you make to instat the deficient practice do not recur? Inspections will be	atic ss rtions re for e t and vill ed by and e PE, nead 00 e put	10/14/2011
	Based on an ob	servation with the			conducted and compliance v	/ill be	

000306

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 01	(X3) DATE : COMPL		
		155694	A. BUI B. WIN	LDING IG		09/14/2	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		•		116 BE			
	JRSING HOME				RN, IN46706		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL.		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
PREFIX TAG	Maintenance Si 09/14/11 at 12 was a combust measuring five at the 300 hall protected with Measurements the Maintenance time of observations of 1 secondance with Sprinkler Syste complete cover of the building practice was not to 1 secondance with sprinkler syste complete cover of the building practice was not to 29/14/11 at 12/14/11 at 12/14	upervisor on 2:48 p.m., there ible overhang feet and five inches exit which was not sprinklers. were provided by ce Supervisor at the ation. poservation and facility failed to inkler system plete coverage for 1 e areas in th NFPA 13, the Installation of		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ee ctive e the ur, r the	COMPLETION DATE
	Findings includ	le:					
	Maintenance Si 09/14/11 at 1: which was abo	oservations with the upervisor on 20 p.m., an area ut 36 square feet in between the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BU 155694		(X2) MU A. BUIL B. WINC	DING	01	(X3) DATE S COMPL 09/14/20	ETED	
	PROVIDER OR SUPPLIER			116 BET	DDRESS, CITY, STATE, ZIP CODE Z RD N, IN46706		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	coordinator's of sprinkler covery placement of two on the other side which defined of area. The sprace two sprinklers which bulkhead. The of the area were walls of the off	age due to the vo sprinkler heads de of a bulkhead one side of the y pattern for these was blocked by the e other three sides e defined by the ices and the glass o the corridor. This ged by the upervisor at the					
K0062 SS=D	continuously main condition and are	ic sprinkler systems are tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA					
		acility failed to prinkler systems I in proper working	K0	062	It is the practice of this provice insure that automatic sprinkles system is continuously maintained in a reliable operation. What corrective act will be accomplished for thos residents found to have been	er ating ion e	10/14/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4IPJ21

Facility ID:

000306

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CON	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	01	COMPL	
		155694	B. WING	·		09/14/2	011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDER OR BOTTELLA			116 BET			
	JRSING HOME			AUBURI	N, IN46706		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	P	PREFIX	E	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		residents, staff and			effected by the deficient practice?PIPE, Inc. has		
	visitors.				completed the service on the	:	
					clapper gasket leak.How will		
	Findings includ	le:			identify other residents havin		
					potential to be effected by the		
	Based on recor	d review with the			same deficient practice and v		
	Maintenance Si				corrective action will be taken residents have the potential to		
	09/14/11 at 4:	•			effected by the alleged defici		
		ction report dated			practice. PIPE, Inc. has		
	1 .	•			completed the service on the	!	
	07/08/11 from P.I.P.E. titled "Report of Inspection" stated				clapper gasket leak.What		
					measures will be put into pla what systemic changes will y		
	'' -	t leak threw alarm			make to insure that the defici		
	line. To be ser	viced." Based on an			practice does not recur?Sprii		
	interview with	the Maintenance			system inspections will be		
	Supervisor at tl	he time of record			conducted as required and		
	review, the Cla	pper gasket has not			according to the implemented	d	
	been serviced.				schedule. Maintenance supervisor/designee will mor	itor	
					results and timeliness. How w		
	3.1-19(b)				the corrective action be mon		
					to insure the deficient practic	e will	
					not recur, i.e., what quality		
					assurance program will be pu	ut	
					into place?Maintenance supervisor/designee will com	nlete	
					a Life Safety CQI tool. Resu	•	
					will be reviewed by the CQI		
					commitee and the safety		
					committee, with action plans		
V0069	Combustion and v	ventilation air for boiler,			created as needed		
K0068 SS=D		eater rooms is taken from					
30 ·D	and discharged to	the outside air. 19.5.2.2					
	Based on observation and interview, the facility failed to ensure 1 of 1 kitchen offices was		K00	068	It is the practice of this provide		09/14/2011
					have ventilation air taken from	m the	
					outside for gas fueled water heater.What corrective action	,	
	provided with i	ntake combustion			was accomplished for those	•	

	OF CORRECTION	IDENTIFICATION NUMBER: 155694		LDING	01	COMPL 09/14/2	ETED
	PROVIDER OR SUPPLIEI JRSING HOME SUMMARY S	TATEMENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 116 BETZ RD AUBURN, IN46706				
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	containing fue accordance with 19.5.2.2. This could create as with carbon dicause physical staff in the kito. Findings including Based on obse Maintenance S 09/14/11 at 1 kitchen office water heater with at had been was acknowled.	deficient practice n atmosphere rich exide which could problems for the chen office. de: rvation with the upervisor on 130 p.m., the nad a gas fueled ith a fresh air vent capped off. This lged by the upervisor at the			residents found to have been effected by the deficient practice? The fresh air vent was uncapped immediately by the maintenance supervisor who found and in the presence of surveyors. How will you idented other residents having the potential to be effected by the same deficient paracticer and what corrective action will be taken? No residents had the potential to be affected by the alleged deficient practice as was in a kitchen office area. fresh air vent was uncapped immediately by the maintenast supervisor when found and it presence of the surveyors. In measures will be put into plate what systemic changes will yanke to insure that the deficient practice does not recur? Cert Dietary manager and maintenance supervisor/des will check the vent as part of monthly walk thru to insure the fresh outside air is being protofor the intake of the gas wheater. How will the corrective action be monitored to insure deficient practice will not recite., what quality assurance program will be put into place? Maintenance supervisor/designee will coma Life Safety CQI tool. Resulting the reviewed by the CQI commmittee and the Safety committee if an action plan is necessary.	vas e e n f the htify e d e this The ance n the What ace or you ient iffied ignee i their hat vided ater e e the ur,	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		01	(X3) DATE COMPI		
		155694	B. WIN			09/14/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER			116 BE			
BETZ NU	JRSING HOME				RN, IN46706		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0069 SS=E	•	are protected in accordance .2.6, NFPA 96					
	Based on obser	vation and	K(0069	It is the practice of this provide		10/14/2011
	interview, the f	acility failed to			insure that there is a placard indicating that the K Class		
	maintain 1 of 1	K Class portable			extinguisher is to be used as		
	fire extinguishe	ers in the kitchen			supplemental protection to the		
	cooking area in	accordance with			automatic fire suppression		
	the requiremen				system.What corrective action	n will	
	Standard for Po				be accomplished for those residents found to have been	1	
		1998 Edition. NFPA			effected by the deficient	•	
	10, 2- 3.2 requ				practice?A placard has been		
	· ·	provided for the			mounted next to the K class	•	
	-	ooking appliances			portable extinguisher indicati that it is to be used as	ing	
	-	tible cooking media			supplemental protection to the	ne	
	_	nimal oils and fats)			automatic fire suppression		
	shall be listed a				system.How will you identify		
					residents having the potentia		
		NFPA 10, 2-3.2.1			be effected by the same defi practice and what corrective	cient	
	requires a placa				action will be taken?Any resi	dents	
		placed near the			using the main dining room		
	_	hich states the fire			adjacent to the kitchen could		
	protection syst				effected by the alleged defici practice. A placard has been		
	-	to using the fire			mounted next to the K class		
	-	Since the fixed fire			portable extinguisher indicat	ing	
	extinguishing s	system will			that it is to be used as		
	automatically s	hut off the fuel			supplemental protection to the	ne	
	source to the c	ooking appliance,			automatic fire suppression system.What measures will l	ne	
	the fixed syster	m should be			put into place or what system		
	activated befor	e using a portable			changes will you make to ins	sure	
	fire extinguishe	er. In this instance,			that the deficient practice do	es	
	_	e extinguisher is			not recur? Certified Dietary		
	=	protection. This			manager and maintenance supervisor/designee will che	ck	
		ce could affect any			the placard as part of their		
	-	the main dining			monthly walk thru to insure t		
					is still in place as instruction	for	
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	4IPJ21	Facility	ID: 000306 If continuation s	heet Pa	ge 25 of 33

	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE COI LDING	01	COMPL	ETED
		155694	B. WIN			09/14/2	011
NAME OF I	PROVIDER OR SUPPLIER	₹		1	DDRESS, CITY, STATE, ZIP CODE		
BETZ NU	JRSING HOME			116 BET AUBUR	N, IN46706		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	room, located kitchen. Findings included Based on obse Maintenance Science Sc	adjacent to the de: rvation with the upervisor on :35 p.m., the s fire extinguisher rd. Based on an the Maintenance he time of ne kitchen K Class er lacked a placard use as secondary kitchen automatic			employees. All dietary staff be inserviced about the K cla extinguisher and it's use. How the corrective action be more to insure the deficient praction not recur, i.e., what quality assurance program will be provided into place? Maintenance supervisor/designee will comma Life Safety CQI tool. Resurance and the Safety committee and the Safety committee if an action plan in necessary	ass w will itored ce will ut nplete ults	

1 '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CO	` '		(3) DATE SURVEY COMPLETED	
155694		A. BUILDING 09/14/2011						
		100001	B. WING	TERRET A	DDDEGG CITY CTATE TID CODE	00/11/2	011	
NAME OF PROVIDER OR SUPPLIER			I .	116 BET	DDRESS, CITY, STATE, ZIP CODE			
BETZ N	JRSING HOME				N, IN46706			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION	
K0074 SS=C	Draperies, curtain and other loosely serving as furnish care occupancies provisions of 10.3 for the Installation Shower curtains a 701. Newly introduced health care occup specified when te methods cited in 19.7.5.1, NFPA 13. Newly introduced specified when te method cited in 10.1. Based on ol interview, the ensure window 69 resident rooms were fladeficient pract number of resident pract number nu	mattresses meet the criteria sted in accordance with the 0.3.2 (3), 10.3.4. 19.7.5.3 oservation and facility failed to v curtains in 49 of oms, 1 of 1 lounges d 1 of 1 Restorative ame retardant. This ice could affect any dents. de: rvations with the appervisor on 12:35 p.m. to 2:10 ow curtains ty nine resident 0 hall lounge and a room lacked	K007	74	It is the practice of this provi provide the flame retardent ratings of window curtains. also the practice to have 1/2 diagonal mesh cubicle curta the shower rooms. What corrective action will be accomplished for those reside found to have been effected the deficient practice? Fire rapaperwork was found by the maintenance supervisor the day. The one cubicle curtain replaced that day as well with that met the standard. How we you identify other residents having the potential to be effected by the same deficient practice and what corrective action we taken? All residents have the potential to be effected by the alleged deficient practice. Frating paperwork was found the maintenance supervisor	It is inch ins in dents by ating next n was ch one will fected be rie ire by	09/15/2011	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 01	(X3) DATE: COMPL 09/14/2	ETED
NAME OF PROVIDER OR SUPPLIER BETZ NURSING HOME				116 BET	DDRESS, CITY, STATE, ZIP CODE IZ RD N, IN46706		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	flame retardan interview with Supervisor at 1 was no docume flame retardan curtains availal 3.1–19(b) 2. Based on ol interview, the flame esprinkle cubicle curtain of 6 shower ro accordance with Sprinkler Systellack of cubicle sprinkler location which may obsopray onto the the heat from the heat from the heat from the ficient practice in the room. Findings include Based on obse Maintenance Sto 19/14/11 at 2	the Maintenance 2:35 p.m., there entation regarding cy for these window ole for review. Deservation and facility failed to ers in areas where s were installed in 1 oms was in th NFPA 13, the Installation of tms. Due to the curtain and on coordination truct the sprinkler fire or may shield the sprinkler, this the could affect any 400 hall shower			next day. The one cubicle of was replaced that day as we one that met the standard. We measures will be put into plat what systemic changes will make to insure that the deficit practice does not recur? All materials will be logged and flame spread rating sheets for with the maintenance direct binder or folder. Current flame rates will be kept in a folder maintenance supervisor/designee. Management team will be inserviced on where these it are found and to make sure cubicle curtains have the 1/2 diagonal mesh at the top dut their customer care or week manager rounds. How will the corrective action be monitore insure the deficient practice not recur, i.e., what quality assurance program will be pinto place? A Life Safety CQI will be utilized and reviewed the maintenance supervisor/designee. Result be reviewed at the monthly simeeting if indicated.	ell with //hat //h	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		STRUCTION 01	(X3) DATE S COMPL	
		155694	B. WING			09/14/2	011
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RET7 NI	JRSING HOME			6 BETZ	Z RD I, IN46706		
		TATEMENT OF DEPLOIPNING			, III-0700	-	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	curtain that lace diagonal mesh open weave top 18 in. below the deflector. This by the Maintenanthe time of observations of the time of the ti	ked 1/2 inch or a 70 percent o panel extending e sprinkler was acknowledged ance Supervisor at ervation. //gen is: n any portion of a facility are housed, examined, or ation of a fire barrier of e construction; is mechanically ventilated, as ceramic or concrete ed with signs indicating that turring, and that smoking in a is not permitted in IFPA 99 and the Association. 8.6.2.5.2 evation and acility failed to reas used for oxygen was any portion of a		.G	It is the practice of this provide insure that a one hour fire resistive door be on the oxyg transferring room. What correaction will be accomplished for those residents found to have been effected by the deficien	ler to en ctive or	
	facility wherein housed. examin	residents are ned, or treated by			practice? A new door was ord 9-29-11. It is to arrive by 10-		
		fire barrier of 1			and will be installed within the		
	-	ive construction.			next 2 business days	_{6,}	
	This deficient p	oractice could affect			thereafter.How will you identi other residents having the	ıy	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4IPJ21

Facility ID:

000306

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155694		(X2) MULTIPI A. BUILDING		01 	(X3) DATE S COMPL 09/14/20	ETED	
	PROVIDER OR SUPPLIER		116	6 BETZ	DRESS, CITY, STATE, ZIP CODE Z RD , IN46706	03/14/2	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
K0147 SS=F	Maintenance Su 09/14/11 at 2: to the oxygen to was a twenty me door. This was the Maintenance time of observations. 3.1–19(b)	e: servation with the opervisor on 35 p.m., the door ransferring room inute fire rated acknowledged by e Supervisor at the operation.			potential to be effected by the same deficient practice and we corrective action will be taken? The alledged deficient practice could effect any reside that was near the oxygen roomew door was ordered 9-29-3 is to arrive by 10-7-11 and wite installed within the next 2 business days thereafter. What measures will be put into place what systemic changes will ymake to insure that the deficit practice does not recur? The regulations will be monitored. The Maintenance supervisor/designee will make internal changes if NFPA 99 requires a higher fire resistive rating on oxygen transferring rooms. How will the corrective actions be monitored to insure deficient practice will not recuive., what quality assurance program will be put into place? The Executive Director responsible to ensure complish ymonitoring regulatory charcommunicated by Life Safety consultant.	dent m. A l1. It ll be at ce or ou ent ethe ethe lir, r is ance nges	
	as an extensior used as a subst wiring. LSC 9.1	acility failed to exible cords such cord were not citute for fixed	K0147		It is the practice of this providinsure that electrical wiring an equipment is in accordance vistandards. What corrective Adwass accomplished for those residents found to have been effected by the deficient practice? Extension cord for the emergency generator was	nd vith ction	09/15/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01		01	COMPLETED	
	15560 <i>1</i>		B. WIN			09/14/2	011
		II.	D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		116 BE			
BETZ NU	JRSING HOME			1	N, IN46706		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	comply with NI	FPA 70, National			replaced by a new outlet	_	
	Electrical Code	, 1999 Edition.			installation. The extension of		
		le 400–8 requires			on the coffee pot in the temp activity office was removed.	•	
	unless specific	·			GFCI receptacle in the 200 h		
	•	and cables shall not			clean utility has been rewired		
					is working properly.How will		
		ubstitute for fixed			identify other residents havin	•	
	wiring of a stru				potential to be effected by the		
		ice could affect all			same deficient practice and value corrective action will be	wnat	
	occupants sho	uld a problem arise			taken?None of these findings		
	at the emerger	ncy generator.			were in areas that woul have		
					directly effected residents.		
	Findings includ	de:			Extension cord for the emerg		
	j.				generator was replaced by a		
	 Based on an ol	oservation with the			outlet installation. The exten	sion	
	Maintenance S				cord on the coffee pot in the temporary activity office was		
					removed. The GFCI recepta	cle	
		veen 1:45 p.m. and			in the 200 hall clean utility ha		
	· -	ension cords were		been rewired and is working			
		llowing locations:	properly.What measures will be				
	1	ght weight extension		put into place or what systemic			
	cord was plugg	ged in and providing			changes will you make to ins that the deficient practice do		
	power to a mu	ltiplug adapter			not recur?Extension		
	which was sup	plying power to the			cords(flexible cord and lightw	eight	
	coolant heater	and the blocker			extension cables) are not to	be	
		mergency generator			used.How will the corrective		
					actions be monitored to insur		
	b) a regular light weight				deficient practice will not reci i.e., what quality assurance	ui,	
	extension cord was providing				program will be put into		
	power to a coffee pot in the				place?Life Safety CQI tools v	vill	
	Activities office. This was acknowledged by the				be completed by the mainter		
					supervisor/designee. Data		
		upervisor at the			collected will be submitted to		
	time of observ	ations.			CQI committee for review an		
					action plan developed if three is not met. The Executive	oi iUiU	
	3.1-19(b)				Director is responsible to ens	sure	
					•		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIIII	A. BUILDING B. WING			COMPLETED 09/14/2011	
		155694						
			-		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	(116 BE	TZ RD			
BETZ NU	JRSING HOME			L	N, IN46706			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	compliance.		DATE	
					compliance.			
	2. Based on ol	oservation and						
	interview, the f	acility failed to						
	ensure 1 of 1 v	vet locations in the						
	200 hall clean	utility room was						
	provided with	ground fault circuit						
	interrupter (GF	CI) protection						
	against electric	shock. NFPA 70,						
	Article 517, He	alth Care Facilities,						
	defines wet loc	ations as areas						
	subjected to w	et conditions.						
	I -	standing fluids on						
		enching of the work						
		which condition is						
	· ·	patient or staff.						
		20 Wet Locations,						
		eptacles and fixed						
	•	hin the area of the						
	wet location to							
		oisture can reduce						
	1 '							
		istance of the body,						
		nsulation is more						
		re. This deficient						
	_ ·	affect any staff						
	using the sink							
	1	om in the event of						
	an electrical sh	ort.						
	Findings includ	lo:						
	i mamys meluc	IC.						
		oservation with the						
	Maintenance Si	•						
	09/14/11 at 1:	:40 p.m., the 200						

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155694	(X2) MULTIPLE CC A. BUILDING B. WING	01	li i	e survey Pleted /2011
	PROVIDER OR SUPPLIER		116 BE	ADDRESS, CITY, STATE, ZIP C TZ RD RN, IN46706	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	wall within three sink. When the GFCI receptacle power was interested with a G and the button was pressed, printerrupted. A lights on the G indicated the G not wired corrested.	receptacle on the ee feet of a hand e test button on the e was pressed, rrupted. But when FCI testing device was testing device ower was not lso the indicator FCI testing device FCI receptacle was ectly. This was by the Maintenance				